		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033704

Facility Name: DEICKE CTR-MARKLUND CHL HOME

Address: 27W751 Shady Way Lane (Number) Winfield (City) 60190 (Zip Code)

County: DuPage

Telephone Number: (630) 593-5479 **Fax #** (630) 593-5481

IDPA ID Number:

Date of Initial License for Current Owners: 03/18/89

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT			[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
	[X] Charitable Corp.				[ ] Individual		[ ] State
	[ ] Trust				[ ] Partnership		[ ] County
IRS Exemption Code	501 (c) 3				[ ] Corporation		[ ] Other
					[ ] "Sub-S" Corp.		
					[ ] Limited Liability Co.		
					[ ] Trust		
					[ ] Other		

In the event there are further questions about this report, please contact:
Name: Lisa Lipira **Telephone Number:** (630) 593-5479

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/03 to 06/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Lisa Lipira
(Title) CFO/Executive Director

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	42	Skilled Pediatric (SNF/PED)	42	15,372	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	42	TOTALS	42	15,372	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	14,336	672		15,008	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,336	672		15,008	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.63%

D. How many bed-hold days during this year were paid by Public Aid?
262 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 03/18/04

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1988 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/04 Fiscal Year: 06/30/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	186,102	8,435	9,135	203,672		203,672		203,672			1
2	Food Purchase		114,330		114,330		114,330		114,330			2
3	Housekeeping	64,580	17,508		82,088		82,088		82,088			3
4	Laundry	17,597	8,364		25,961		25,961		25,961			4
5	Heat and Other Utilities			60,468	60,468		60,468		60,468			5
6	Maintenance	20,800	13,765	27,089	61,654		61,654		61,654			6
7	Other (specify):* Disposal			9,693	9,693		9,693		9,693			7
8	**TOTAL General Services**	289,079	162,402	106,385	557,866		557,866		557,866			8
	B. Health Care and Programs											
9	Medical Director			14,917	14,917		14,917		14,917			9
10	Nursing and Medical Records	1,251,596	121,438	400,655	1,773,689	(83,767)	1,689,922		1,689,922			10
10a	Therapy	81,217	2,638	11,703	95,558		95,558		95,558			10a
11	Activities	37,440	10,237	504	48,181		48,181		48,181			11
12	Social Services	16,058			16,058		16,058		16,058			12
13	Nurse Aide Training		96		96	11,821	11,917		11,917			13
14	Program Transportation	12,064		14,609	26,673		26,673		26,673			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,398,375	134,409	442,388	1,975,172	(71,946)	1,903,226		1,903,226			16
	C. General Administration											
17	Administrative	55,016			55,016		55,016		55,016			17
18	Directors Fees											18
19	Professional Services			20,633	20,633		20,633	(13,188)	7,445			19
20	Dues, Fees, Subscriptions & Promotions			49,410	49,410		49,410	(19,086)	30,324			20
21	Clerical & General Office Expenses	183,165	48,919	28,837	260,921	(3,037)	257,884		257,884			21
22	Employee Benefits & Payroll Taxes			371,176	371,176		371,176		371,176			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,868	5,868		5,868		5,868			24
25	Other Admin. Staff Transportation			11,838	11,838		11,838		11,838			25
26	Insurance-Prop.Liab.Malpractice			62,295	62,295		62,295		62,295			26
27	Other (specify):* Fundraising/Promo			24,049	24,049		24,049	(24,049)				27
28	**TOTAL General Administration**	238,181	48,919	574,106	861,206	(3,037)	858,169	(56,323)	801,846			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,925,635	345,730	1,122,879	3,394,244	(74,983)	3,319,261	(56,323)	3,262,938			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME #0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			139,018	139,018		139,018	(43,756)	95,262			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,452	5,452		5,452	(5,452)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			55,628	55,628		55,628	(55,628)				34
35	Rent-Equipment & Vehicles					3,037	3,037		3,037			35
36	Other (specify):*											36
37	**TOTAL Ownership**			200,098	200,098	3,037	203,135	(104,836)	98,299			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					71,946	71,946		71,946			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			170,464	170,464		170,464		170,464			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			170,464	170,464	71,946	242,410		242,410			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,925,635	345,730	1,493,441	3,764,806		3,764,806	(161,159)	3,603,647			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	5,452	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	19,086	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	13,188	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	24,049	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Non-Care Related Assests	43,756	30		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 105,531		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	55,628	34	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 55,628		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 161,159		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

DEICKE CTR-MARKLUND CHL HOME

ID# 0033704

Report Period Beginning: 07/01/03

Ending: 06/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Fundraising/Promotional	$ 55,628	34	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	55,628		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME **#** 0033704 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	13,188	0	0	0	0	0	0	0	0	0	0	13,188	19
20	Fees, Subscriptions & Promotions	19,086	0	0	0	0	0	0	0	0	0	0	19,086	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	24,049	0	0	0	0	0	0	0	0	0	0	24,049	27
28	**TOTAL General Administration**	56,323	0	0	0	0	0	0	0	0	0	0	56,323	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	56,323	0	0	0	0	0	0	0	0	0	0	56,323	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	5,452	0	0	0	0	0	0	0	0	0	0	5,452	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	111,256	0	0	0	0	0	0	0	0	0	0	111,256	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	116,708	0	0	0	0	0	0	0	0	0	0	116,708	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	173,031	0	0	0	0	0	0	0	0	0	0	173,031	45

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Cost Budget	12,876,286	12,876,286	$ 457	$	2,738,669	$ 97	1
2	2	Food	Direct Cost Budget	12,876,286	12,876,286	2,134		2,738,669	454	2
3	3	Housekeeping	Direct Cost Budget	12,876,286	12,876,286	12,900		2,738,669	2,744	3
4	5	Utilities	Direct Cost Budget	12,876,286	12,876,286	61,629		2,738,669	13,108	4
5	6	Maintenance	Direct Cost Budget	12,876,286	12,876,286	22,512		2,738,669	4,788	5
6	7	Disposal	Direct Cost Budget	12,876,286	12,876,286	30,499		2,738,669	6,487	6
7	13	BNATP	Direct Cost Budget	12,876,286	12,876,286	450		2,738,669	96	7
8	14	Transportation	Direct Cost Budget	12,876,286	12,876,286	233		2,738,669	50	8
9	19	Professional Services	Direct Cost Budget	12,876,286	12,876,286	35,004		2,738,669	7,445	9
10	20	Fees, Subscription	Direct Cost Budget	12,876,286	12,876,286	129,044		2,738,669	27,446	10
11	21	Clerical/Office	Direct Cost Budget	12,876,286	12,876,286	656,826	488,661	2,738,669	186,900	11
12	22	Benefits	Direct Cost Budget	12,876,286	12,876,286	94,192		2,738,669	29,132	12
13	24	Travel & Seminars	Direct Cost Budget	12,876,286	12,876,286	13,428		2,738,669	2,856	13
14	25	Staff Transportation	Direct Cost Budget	12,876,286	12,876,286	22,028		2,738,669	4,685	14
15	26	Insurance	Direct Cost Budget	12,876,286	12,876,286	14,004		2,738,669	2,979	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,095,340	$ 488,661		$ 289,267	25

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	N/A											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

** **If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	N/A	8
2000		9
2001		10
2002		11
2003		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DEICKE CTR-MARKLUND CHL HOME COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0033704

CONTACT PERSON REGARDING THIS REPORT Lisa Lipira

TELEPHONE (630) 593-5500 FAX #: (630) 593-5481

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-13-100-001,002,003	Residential - Tax Exempt	$ None	$ None
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? N/A YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 10,250 B. General Construction Type: Exterior Brick Frame Brick/Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	110,816	Apr-88	$ 100,000	1
2					2
3	TOTALS	110,816		$ 100,000	3

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	42		1988	1964	$ 669,211	$ 33,461	20	$ 33,461	$	$ 552,099	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Replacement of circular drive - Land impr.			1990	1,725		5			1,725	9
10	black top work on driveway - Land Impr			1992	2,484		5			3	10
11	resurfacing of parking lot - Land impr.			1993	810		5			810	11
12	removal/replacement of sidewalk - Land impr			1994	600		5			600	12
13	stone bed work - Land impr.			1995	2,490		5			2,490	13
14	tree trimming/landscaping - Land impı			1996	3,055		5			3,055	14
15	pavement,asphalt - Land impr.			1996	15,000		5			15,000	15
16	Concrete Work - Land impr.			1999	6,460	646	5	646		5,814	16
17	Landscaping Land impr.			2000	1,236	247	5	247		865	17
18	Nature Trail - Land impr.			2000	2,100	420	5	420		1,470	18
19	Replace Parking Lot/Asphalt - Land impr.			2000	5,566	557	5	557		5,009	19
20	Repair and Resurface Driveway - Land impr.			2000	24,907	4,981	5	4,981		12,454	20
21	Brick Patio			2003	6,025	603	5	603		603	21
22	Seal Coat/Striping parking-lot			2003	3,497	874	2	874		874	22
23	Security system			1988	2,055		10			2,055	23
24	renovations			1989	230,082	11,504	20	11,504		166,810	24
25	exterior canopy			1990	4,303	215	20	215		2,689	25
26	signage			1990	1,803		10			1,803	26
27	canopy sprinkler			1990	1,148		10			1,148	27
28	exterior staining			1991	2,650	291	5	291		2,650	28
29	storage shed			1992	899		5			899	29
30	windows			1993	5,838		10			5,838	30
31	retile tubs			1993	2,000		5			2,000	31
32	ac repair/renovation			1993	547		5			547	32
33	roof repair			1993	2,150	590	5	590		2,150	33
34	kitchen floor			1993	5,000		5			5,000	34
35	gutters, downspouts, soffi			1994	5,900		10			5,015	35
36	master key system			1994	607	377	5	377		607	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Tiling kitchen walls	1995	$ 1,400	$	5	$	$	$ 1,400	37
38	Water heater	1995	3,765		5			3,200	38
39	Anti-Freeze Loop system for Fire Protection	1999	2,532		25			456	39
40	Painting	1999	4,250		5			3,825	40
41	Water Heater	1998	4,450		5			4,450	41
42	Floor repair	1997	1,220		10			671	42
43	New Water Closet	1999	732		10			329	43
44	vestibule addition	1999	42,700		15			19,215	44
45	exhaust fan	1999	2,000		5			600	45
46	siding	1999	2,135		25			1,922	46
47	fire alarm fitting	1999	312		10			56	47
48	auto doors new enclosure	1999	11,547		5			5,196	48
49	flooring new entrance	1999	1,383		5			1,245	49
50	painting & renovation	1999	2,650		5			2,385	50
51	air curtain	1999	767		5			690	51
52	air curtain	1999	934		5			840	52
53	flooring/carpeting	1999	42,747		15			38,472	53
54	soffits/ceiling/plumbing upgrades	1999	72,156		10			24,233	54
55	Electric sliding door	2000	1,322		5			661	55
56	New Tile Flooring	2002	1,398		5			419	56
57	Hot Water Heater	2001	3,500		15			350	57
58	Generator	2001	2,345		5			704	58
59	Six windows replaced	2003	3,030	303	5	303		303	59
60	Venilation system upgrade	2004	3,244	324	5	324		324	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,222,667	$ 55,393		$ 55,393	$	$ 914,028	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 118,288	$ 26,640	$ 26,640	$		$ 89,193	71
72	Current Year Purchases	15,916	1,965	1,965			1,965	72
73	Fully Depreciated Assets	190,593					190,593	73
74								74
75	TOTALS	$ 324,797	$ 28,605	$ 28,605	$		$ 281,751	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	1999 Isuzu Truck	1999	$ 31,554	$ 3,945	$ 3,945	$		$ 31,554	76
77	General Use	1996 Ford 4x4	1996	20,537					20,537	77
78	Patient Transport	1999 Bluebird Bus	1998	73,186	7,319	7,319			73,186	78
79										79
80	TOTALS			$ 125,277	$ 11,264	$ 11,264	$		$ 125,277	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,772,741	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 95,262	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 95,262	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,321,056	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 3,037 Description: Office Equipment/Machinery
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	Line 39, Col.8	2409	52,998			18,948	2,409	71,946	12
13	Other (specify):									13
14	TOTAL			$ 52,998		$	$ 18,948	2,409	$ 71,946	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,537,681	$ 2,537,681	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 101,502)	1,683,233	1,683,233	3
4	Supply Inventory (priced at Cost)	53,700	53,700	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	128,915	128,915	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	582,242	582,242	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,985,771	$ 4,985,771	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,158,615	6,158,615	13
14	Buildings, at Historical Cost	17,654,573	17,654,573	14
15	Leasehold Improvements, at Historical Cost	4,547	4,547	15
16	Equipment, at Historical Cost	4,383,065	4,383,065	16
17	Accumulated Depreciation (book methods)	(8,244,217)	(8,244,217)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	7,054,166	7,054,166	21
22	Other Long-Term Assets (specify):	2,138,042	2,138,042	22
23	Other(specify):	1,678,117	1,678,117	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 30,826,908	$ 30,826,908	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 35,812,679	$ 35,812,679	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 650,291	$ 650,291	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	254,131	254,131	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,330	20,330	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other-compensation&related payables	1,093,628	1,093,628	36
37	Misc. Other	2,465,598	2,465,598	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,483,978	$ 4,483,978	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,483,978	$ 4,483,978	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 31,328,701	$ 31,328,701	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 35,812,679	$ 35,812,679	48

***(See instructions.)**

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 30,365,586	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 30,365,586	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(604,530)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,733,960	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Remaing Consolidated Inc/(Loss)**	(638,267)	15
16	Other (describe) **Change in Unrealized Gains/(Losses)**	525,233	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,016,396	17
	B. Transfers (Itemize):		
18	**Transfer out of Restricted Funds into Operations-Expenses**	(53,281)	18
19	**Transfer out of Restricted Funds into Operations-Capital**	(521,349)	19
20	**Transfer into Operations from Restricted Funds - Capital**	521,349	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (53,281)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 31,328,701	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,968,564	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,968,564	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	1,937	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,937	23
	D. Non-Operating Revenue		
24	Contributions	28,616	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,616	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,999,117	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	557,866	31
32	Health Care	1,903,226	32
33	General Administration	801,846	33
	B. Capital Expense		
34	Ownership	98,299	34
	C. Ancillary Expense		
35	Special Cost Centers	71,946	35
36	Provider Participation Fee	170,464	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,603,647	40
41	**Income before Income Taxes (line 30 minus line 40)****	(604,530)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (604,530)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,976	2,080	$ 78,520	$ 37.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,500	17,368	410,580	23.64	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	54,340	57,200	667,524	11.67	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,845	2,995	71,975	24.03	7
8	Rehab/Therapy Aides	553	582	9,243	15.88	8
9	Activity Director					9
10	Activity Assistants	2,964	3,120	37,440	12.00	10
11	Social Service Workers	988	1,040	16,058	15.44	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,080	41,662	20.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,243	11,835	122,849	10.38	15
16	Dishwashers	1,976	2,080	21,590	10.38	16
17	Maintenance Workers	988	1,040	20,800	20.00	17
18	Housekeepers	7,252	7,634	64,580	8.46	18
19	Laundry	1,976	2,080	17,597	8.46	19
20	Administrator	1,976	2,080	55,016	26.45	20
21	Assistant Administrator					21
22	Other Administrative	5,928	6,240	151,133	24.22	22
23	Office Manager	1,976	2,080	32,032	15.40	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	5,533	5,824	89,981	15.45	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	395	416	4,992	12.00	31
32	Other Health Ca Transportation	988	1,040	12,064	11.60	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	122,373	128,814	$ 1,925,636 *	$ 14.95	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	175	$ 8,795	1	35
36	Medical Director	Monthly	14,917	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	18	540	10a	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	92	2,761	10	42
43	Speech Therapy Consultant	199	11,163	10a	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	8	684	10	46
47					47
48					48
49	TOTAL (lines 35 - 48)	492	$ 38,860		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	5,379	$ 258,187	10	50
51	Licensed Practical Nurses				51
52	Nurse Aides	4,965	139,024	10	52
53	TOTAL (lines 50 - 52)	10,344	$ 397,211		53

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nancy Rodriguez	Administrator		$ 55,016
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,016

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KPMG	Audit Fees	$ 7,445
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 7,445

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,178
Unemployment Compensation Insurance	8,853
FICA Taxes	147,311
Employee Health Insurance	112,870
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	51,087
Dental	9,817
Life Insurance/Disability	1,060
TOTAL (agree to Schedule V, line 22, col.8)	$ 371,176

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	27,446
Health Care Worker Background Check	
(Indicate # of checks performed)	
IHCA Dues	2,155
Misc. Dues/Subscriptions	723
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,324

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,868
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,868

**See instructions.

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number DEICKE CTR-MARKLUND CHL HOME # 0033704 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $2,155**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **27,386** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **No** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **170,464**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **Yes, Sch.8** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **15%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Cost Report **Marklund Deicke** **6015796**
Seminars
FY 04

Date of Seminar	Company Providing Seminar	Persons Attending	Job Tittle	Site	Cost of Seminar
09/14/04	IHCA Conference	Laurie Schaeffer	CTRS		137.30
		Dee Della Rey	QMRP		137.30
		Maggie Gross			137.30
11/11/03	Achievement Systems-Psychotropic Medications	Melissa Muzi	QMRP		16.87
03/16/04	Sanitation Class	Margarito Median	Support Services		50.00
		Cecilia Hernandez	Support Services		50.00
03/17/04	NIDDN - Issues in Developmental Disabilities	Laurie Colles	Nurse		100.00
08/07/03	IHCA Conference-Life Safety Codeo Compliance	Nancy Rodriguez	Administrator		76.67
10/30/03	IHCA - Administrator's License Exam Review	Nancy Rodriguez	Administrator		300.00
	ILTRA Conference - Beyond the Basics				120.00
08/22/03	Amerisafe Training Services_Asbestos Removal Re	Jan Slata	Maintenance Engineer		175.00
12/12/03	Cross Country Univ: Learning/Sensory Dysfunction	Vicky Reyes	PTA		149.00
		Joanna Vicker	PT		149.00
07/18/04	Dietary Managers Associaiton-Annual Conference	Cherl Valdez	Suppoort Services Manager		230.00
04/23/04	DDNA Seminar	Laurie Colles	DON		380.00
08/28/03	Strategic Planning-In House	Joel Rusco	CEO		152.48
		Lisa Lipira	CFO.		152.48
		Lois Kramer	Adminstrator, Therapy/Day Training		152.48
		Kudus Badmus	Director of Finance		152.48
		Joan Rubino	Director of Human Resources		152.48
		Terri Bowen-Weyrich	COO		152.48
		Nancy Rodriguez	Administrator		150.48
		Jeannine Zupo	Director of Marketing/Public Realtions		152.48
	Meeting Dates: 07/09/03, 07/16/03, 08/06/03, 08/13/(	Joel Rusco	CEO		348.82
	08/28/03	Lisa Lipira	CFO.		348.82
		Lois Kramer	Adminstrator, Therapy/Day Training		348.82
		Kudus Badmus	Director of Finance		348.82
		Joan Rubino	Director of Human Resources		348.82
		Terri Bowen-Weyrich	COO		348.82
		Nancy Rodriguez	Administrator		348.80
				Total	5868.00

reason MDH more than MCH =number of clients

Location	Type	Manufacturer	Model	Qty
MDH	Copier	Minolta	DI 450	1
	Fax	Minolta	1800	1
	Copier	Minolta	1030	1

Long term care cost report
Fiscal Year 2004

Marklund Deicke Home

Reclassifications:

Line 10	Exceptional Care Wages	$52,998.00
	Exceptional Care Supplies	$18,948.00
	Training Supplies	$11,821.00
		$83,767.00
Line 13	Training Supplies	$11,821.00
Line 21	Office equipment rental	$3,037.00
Line 35	Office equipment rental	$3,037.00
Line 39	Exceptional Care Program	$71,946.00